

## MASSAGE THERAPY REGISTRATION APPLICATION

**PRINT or TYPE all information on the application. Please answer all questions completely, do not leave any blank. The application and examination fees must be paid in guaranteed funds (cashiers check or money order).**

### APPLICATION CHECK LIST:

#### **BE SURE TO:**

- C Read the Massage Therapy Act (Texas Occupations Code, Chapter 455) and the Rules relating to massage therapy registration (Texas Administrative Code, Chapter 141) before completing application.**
- C Answer all questions on the application completely?**
- C Attach the application fee of \$53.00 (guaranteed funds only)?**
- C Attach an official transcript or notarized copy of your transcript?**
- C Attach a signed photograph?**
- C Attach required documents for question 10 (if you answered yes)?**
- C Have page 3 of the application notarized?**

**If you have a disability and need special accommodation for the examination, you must submit a completed Request for Disability Accommodation Form (one is attached for your use). Submit the request with your complete application.**

**If your primary language is other than English and/or you obtained your massage therapy training in another language, and require an interpreter or other assistance at the examination, please submit your request with the application.**

**Mail all application materials and fee to:**

**Texas Department of Health  
Massage Therapy Registration Program  
P.O. Box 12197  
Austin, Texas 78711-2197**

**Please allow 4-6 weeks for the processing of the application. If you do not receive a response from this office after 6 weeks, you may contact us at:**

**Texas Department of Health  
Massage Therapy Registration Program  
1100 W. 49th St.  
Austin, Texas 78756-3183  
512/834-6616  
massage@licc.tdh.state.tx.us**

**Failure to follow the above instructions may cause a delay in the processing of your application.**

## FEE SCHEDULE

Fees must be paid by cashiers check or money order payable to Texas Department of Health. Cash is accepted when paid in person at the Texas Department of Health office in Austin, Texas.

### Application Fee

Fee must be submitted with completed application.

\$53.00      Application Fee

### Examination Fee

Required after your application is reviewed and after you have received your exam approval letter. (This fee is paid directly to testing company and also must be cashier's check or money order).

\$130.00	First-time exam candidates
\$130.00	Retest - both examinations
\$ 75.00	Retest - practical examination
\$ 55.00	Retest - written examination

### Replacement Registration Fee

Request a duplicate certificate if the registration becomes damaged, lost, or destroyed. You must return the original registration or explain in writing why that is impossible.

\$20.00      Replacement Registration

### Registration Renewal Fee

Your renewal application will be mailed every year to your last known address approximately six (6) weeks prior to the registration expiration date. Failure to timely renew the registration will result in late fees (see below) or the deletion of the registration.

\$40.00      Renewal Fee

### Late Renewal Fees

\$60.00	Renewal postmarked during the first 90 days after registration expiration.
\$80.00	Renewal postmarked more than 90 days but less than one year after registration expiration.

**NOTE:**      *A registration expired for more than one year is not renewable. The person must reapply, meet current registration requirements, and retake the registration examination in order to receive a registration.*

This fee schedule lists the current fees charged by the Massage Therapy Program and is subject to change. It is also not nor is it intended to be an inclusive listing of all fees that the department may statutorily collect. Fee rates are set by the Texas Department of Health as authorized by law in amounts necessary to cover the costs of administering the program and are not mandated by the Texas Legislature.

## MASSAGE THERAPY EXAM INFORMATION

The Texas Department of Health has established the following application deadlines for the Massage Therapy Examinations:

EXAM SCHEDULE	
<u>Examination</u>	<u>Application Deadline</u>
January 2001	Postmarked or In Person 10/13/00 until 5:00 pm
May 2001	Postmarked or In Person 2/09/01 until 5:00 pm
September 2001	Postmarked or In Person 06/08/01 until 5:00 pm

- C Applications received after the deadline will be processed for the next examination.  
**THERE ARE NO EXCEPTIONS**
- C Applicants who have met the education and experience requirements for registration will receive a temporary registration that is valid for six months or until the applicant successfully completes the first examination for which the applicant is eligible. **Please note:** A person whose temporary registration has expired is not eligible to receive another temporary registration. Please refer to Section 141.7 of the massage therapy rules.
- C Students must complete all required hours before they can apply for registration.
- C Incomplete applications will not be considered for the current examination. When the application is complete, it will be considered for the next examination.
- C **Allow 4 - 6 weeks for the processing of an application.** Applications are processed in the order of receipt and as quickly as possible. Please allow sufficient time for the program to process your application before contacting us. Numerous calls inquiring on the status of an application can cause delays in processing. This office currently processes over 1,500 applications per examination.
- C Applicants who are **currently** licensed/registered/certified in another state are not required to take the Texas Massage Therapy Examination (Please refer to Article 4512k, Vernon's Texas Civil Statutes, Section 18.02) **if:**
  - (a) the applicant has been licensed or registered in good standing as a massage therapist for at least two years in another jurisdiction that has licensing or registration requirements substantially equivalent to those in Texas; and
  - (b) the applicant has passed a national massage therapy examination or a state examination for registration or licensing as a massage therapist; and
  - (c) the applicant is sponsored by a Texas Registered Massage Therapist.

**DO NOT PRACTICE MASSAGE THERAPY UNTIL YOU RECEIVE THE TEMPORARY  
REGISTRATION OR REGISTRATION CERTIFICATE**

## MASSAGE THERAPY REGISTRATION APPLICATION INSTRUCTION FORM

**READ** The Massage Therapy Act and TDH Rules before filling out this application. Stated below are the three methods under which a person may apply for registration. Each method lists the documentation that must be submitted with your completed application. Choose one method only and submit appropriate documentation.

### Education

Applicant has satisfactorily completed massage therapy studies in a supervised course of instruction provided by a registered massage therapy instructor, or by a registered massage therapy school, or by a state approved educational institution, or by any combination of instructors or schools.

Please submit:

- C Non-refundable \$53.00 application fee.
- C Official or notarized copy of your transcript
- C A recent full-faced, wallet-sized photograph signed on the back.

**NOTE:** Applicants that have completed their education in another state or country must submit an **official transcript**, a course catalog from the program attended, and verification of the educational program's approval in that state or country by the appropriate education agency.

### Current license/registration/certification in another state:

Applicant is registered as a massage therapist in another state or country that has and maintains standards and requirements of practice and licensing or registration that substantially conform to those of this state, as determined by the department.

Please submit:

- C Non-refundable \$53.00 application fee.
- C Certified copy of the license/registration/certification.
- C License/Registration/Certification Verification (attached) to be completed by the massage therapy licensing authority where the license/registration/certification is held.
- C Current copy of the rules of the other state or country governing its licensing and regulation.
- C A recent full-faced, wallet-sized photograph signed on the back.

**NOTE: Applicants who are currently licensed/registered/certified in another state are not required to take the examination if:**

- (a) the applicant has been licensed/registered/certified in good standing as a massage therapist for at least two years in another jurisdiction that has licensing or registration requirements substantially equivalent to those in Texas; and
- (b) the applicant has passed a national massage therapy examination or a state examination for registration or licensing as a massage therapist; and
- (c) is sponsored by a Texas Registered Massage Therapist.

## Other

Applicant has practiced massage therapy as a profession for not less than five years immediately preceding the application date in another state or country that does not have or maintain standards and requirements of practice and licensing or registration that substantially conform to those of this state, as determined by this department. An applicant must have been employed in the practice of massage therapy as defined in §141.1 for not less than 36 hours per month.

Please submit:

- C Non-refundable \$53.00 application fee.
- C A recent full-faced, wallet-sized photograph signed on the back.
- C Applicants applying under this method must submit two (2) or more of the following:
  - (1) Employer Affidavit Form(s)
  - (2) Client Affidavit Forms
  - (3) Affidavit of Referral Forms or
  - (4) a W-2 form or any other Internal Revenue Service form which reflect receipt of payment for massage therapy services.

**TEXAS DEPARTMENT OF HEALTH  
MESSAGE THERAPY REGISTRATION PROGRAM  
P.O. BOX 12197, AUSTIN, TEXAS 78711-2197**

**BUDGET ZZ014  
FUND 105**

**Type or Print Legibly. Incomplete applications will not be processed. Attach the \$53.00 application fee to the upper left hand corner of this page. Send guaranteed funds (cashiers check or money order) only. Failure to do so may delay processing. Use N/A for not applicable.**

**PERSONAL INFORMATION**

1. Last Name _____	First Name _____
2. Middle Name _____	Maiden Name _____
3. Other Names Formerly Used _____	
4. Preferred Mailing Address _____ P.O. Box or Street Address City _____ State _____ Zip _____ Telephone Number (Include Area Code) _____ E-mail Address _____ Fax Number _____	
5. Residence Address ( if same as 4, WRITE SAME) _____	
6. Birth date (mm/dd/yy) _____	
7. Social Security # _____ - _____ - _____ (Disclosure of a social security number by an applicant is mandatory under the Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes required by law.)	

**8. OTHER LICENSING INFORMATION**

<b>a.</b> Do you possess a massage therapy license(s), registration(s), certification(s) issued by any other state(s), jurisdiction, or territory? <b>9 Yes    9 No</b>  If <b>YES</b> , give license or certificate number(s), title(s), name(s), and address(es) of the jurisdiction(s) issuing the license(s) or certificate(s) _____ _____ _____	
<b>b.</b> Have you taken a national or state certification or licensing examination for massage therapy? <b>9 Yes    9 No</b>  If <b>YES</b> , give the name of the exam, date taken, and the results of the exam _____ _____ _____	
<b>c.</b> Have you ever been denied or have you ever surrendered a professional or occupational license, registration, or certificate? <b>9 Yes    9 No</b> If <b>YES</b> , briefly state the reason(s) _____ _____ _____	
<b>d.</b> Have you ever had a professional or occupational license(s), registration(s), or certificate(s) revoked, canceled, or suspended? <b>9 Yes    9 No</b> If <b>YES</b> , briefly state the reason(s) _____ _____ _____	

## 9. CURRENT EMPLOYMENT INFORMATION

Are you CURRENTLY employed? <b>9 Yes</b> <b>9 No</b>		
Place of Employment		
Address		
City	State	Zip
Telephone Number (Include area code)		
Job Title	Type of Business	
Date of Employment (mm/yy)		

## 10. ADDITIONAL INFORMATION

<p>Have you ever been convicted of a felony or misdemeanor?    <b>9 Yes</b>    <b>9 No</b></p> <p>Have you ever entered a plea of nolo contendere, entered a plea of guilty, or received deferred adjudication for a felony or misdemeanor?    <b>9 Yes</b>    <b>9 No</b></p> <p><i>If you answered yes to either of the above, provide the following information and documents for all felony and/or misdemeanor offenses (not minor traffic violations). Include any convictions which are currently on appeal. Attach additional information/documentation if appropriate.</i></p> <p>Indicate offense(s) committed _____</p> <p>Date(s) of conviction(s) _____ Sentence(s) _____ Fine(s) _____</p> <p>City, County, and State where offense(s) committed _____</p> <p>List other names you have used (e.g. married/maiden, etc) _____</p> <p>Are/were you on probation/parole?    <b>9 Yes</b>    <b>9No</b></p> <p>If YES, discharge date _____</p> <p><b>Submit copies of charging documents (referred to as indictment or information) and judgement or other documents showing disposition of the case(s). If still on parole/probation, submit letter from parole or probation officer indicating compliance with all parole or probationary conditions.</b></p> <p><b>NOTE: Failure to report convictions may result in denial of the application or revocation of registration.</b></p>
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## 11. PHOTOGRAPH SUBMISSION

<p>This photograph will be used in connection with your application for registration and for the purposes of complaint violation(s). It will not be made available to any person who grades your examination nor to any person who makes any decision concerning your employment.</p> <p>Attach a full-faced, wallet-size photograph (minimum size 1½" X 1½") of applicant's head and shoulders <b>ONLY</b>. Use tape to secure your photograph to page. <b>Do not staple or glue</b>. Photograph must have been taken <b>within the two year period</b> prior to application. Sign the reverse side of the photo with your signature as it appears on the application.</p>	<p><b>ATTACH PHOTO HERE:</b></p>
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**Please Read Carefully**

In making application to the Texas Department of Health registration as a massage therapist, I have read and agree to abide by the Massage Therapy Act and the rules of the Board of Health relating to the registration of massage therapists. The disclosure of a social security number by an applicant is mandatory under the Family Code, Section 231.302 and the Health Insurance Portability and Accountability Act of 1996, Section 221. Social Security numbers are confidential and will be used for identification and reporting purposes as required by law. I also agree to complete all application requirements for the processing of my application.

I further understand that the fee submitted with this application is nonrefundable and that the materials submitted for consideration become the property of the department and are nonreturnable. I am aware of the schedule of fees and understand that additional fees must be paid prior to the issuance of a registration certificate and to keep the registration current.

I further agree that if issued a registration certificate, upon the revocation, or cancellation of that registration, I shall return the registration certificate and registration identification card to the department.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**AFFIDAVIT:**

I hereby certify that this application and any attachments contain no willing or negligent misrepresentation or falsification and that the information given by me is true and complete. I understand that should an investigation disclose any such misrepresentation or falsification, my application will be rejected. I will allow the department to verify any information contained in these application materials.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

THE STATE OF )

COUNTY OF )

BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_,

known to me to be the person whose name is subscribed to the foregoing instrument, and having been by me first duly sworn on oath, acknowledge that he/she had executed the same for the purposes and considerations therein expressed and that the foregoing statements are true and correct.

GIVEN under my hand and seal of office, this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

Notary Public in and for \_\_\_\_\_ County, Texas or \_\_\_\_\_.

SEAL

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Name of Notary

\_\_\_\_\_  
Commission Expiration Date



## Request for Disability Accommodation

If you have a disability requiring appropriate accommodations in taking the state examination, be sure to complete and submit this form along with the application. In addition, please attach a statement from a professional who is familiar with your disability on letterhead stationery. This statement must describe the disability for which you require accommodation.

1. Do you have any disability-related needs that we should be made aware of in order to provide appropriate accommodations for the examination? If the answer is yes, please specify.

Disability \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Have you had any prior accommodations for your disability in an examination setting? If you answer "yes", specify the type of accommodation. Have a professional familiar with your disability complete this information, if needed.

Disability	Type of Test Accommodation
_____	_____
_____	_____
_____	_____

3. If you have NOT had prior accommodation for a test, what do you feel would aid you in taking the examination? If you cannot answer this question by yourself, have a professional who knows your disability and the type of accommodation you need help answer this question. This professional could be a physician, psychologist, rehabilitation counselor, or other professional.

Disability	Type of Test Accommodation
_____	_____
_____	_____
_____	_____

Please sign and date the bottom of this form. Make sure the professional who helps you complete this form also signs and dates this form.

_____ Signature (Applicant)	_____ Date
_____ Signature (Professional)	_____ Date

**MASSAGE THERAPY REGISTRATION PROGRAM  
Employment Affidavit**

**Instructions:** This form is to document employment experience. Please use a separate employment affidavit for each organization or institution where the experience was gained. Refer to the Instruction/Declaration Form, method 3 and to §141.4& §141.5 of the rules. Submit experience sufficient to document the five-year requirement. Photocopy this form if additional copies are needed.

**Section I. (Completed by applicant)**

Name of Applicant: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_  
P.O. Box or Street No. City State Zip

**Section II. (Completed by employer)**

The employer certifying to his/her knowledge the experience of the applicant listed above in Section I shall complete the information below:

I, \_\_\_\_\_, certify that I have employed \_\_\_\_\_

from \_\_\_\_\_ to \_\_\_\_\_ and that said person was employed as follows:  
Mo/Day/Yr Mo/Day/Yr

1. Address of Employment \_\_\_\_\_

2. Briefly describe techniques practiced \_\_\_\_\_

3. Job Title \_\_\_\_\_

4. Check type of establishment or office in which work was performed:

G Massage Establishment G Health Spa G Doctor's Office G Other \_\_\_\_\_

5. Total number of hours per month applicant worked in the above duties \_\_\_\_\_

6. Other pertinent information: \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, in \_\_\_\_\_, \_\_\_\_\_  
City State

**Section III. (Completed by notary and employer)**

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )  
COUNTY OF ( )

Sworn to and subscribed before me on  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.  
My commission expires: \_\_\_\_\_.

\_\_\_\_\_  
Signature of Employer

\_\_\_\_\_  
Address of Employer

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Notary's Signature

SEAL

**MASSAGE THERAPY REGISTRATION PROGRAM  
Client Affidavit Form**

**Instructions:** This form is to document client references. The following information must be certified by two or more clients. Submit client affidavits sufficient to document five years of experience. Photocopy this form for each client. Refer to the Instruction/Declaration Form, Method 3 and to §141.4 and 141.5 of the rules. This information shall be used for no other purpose than to verify the five year experience requirement.

**Section I. (Completed by applicant)**

Name of Applicant: \_\_\_\_\_  
Address of Applicant: \_\_\_\_\_  
P.O. Box or Street No. City State Zip

**Section II. (Completed by client)**

**Attach copies of receipt(s) for massage therapy rendered. (This is a rule requirement.)**

The client certifying to his/her knowledge the experience of the applicant listed above in Section I shall complete the information below:

I, \_\_\_\_\_, certify that I have been the client of \_\_\_\_\_  
Applicant  
from \_\_\_\_\_ to \_\_\_\_\_ and that I know of my own knowledge that said person was engaged in  
Mo/Day/Yr Mo/Day/Yr  
the professional practice of massage therapy as follows:

1. Address of business \_\_\_\_\_
2. Briefly describe techniques practiced \_\_\_\_\_  
\_\_\_\_\_
3. Number of hours per month \_\_\_\_\_
4. Check type of establishment or office in which work was performed:  
☐ Message Establishment ☐ Health Spa ☐ Doctor's Office ☐ Other: \_\_\_\_\_
5. Other pertinent information \_\_\_\_\_

**Section III. (Completed by notary and client)**

On this \_\_\_\_\_ day of \_\_\_\_\_, 19\_\_\_\_, in \_\_\_\_\_, \_\_\_\_\_  
City State

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )  
COUNTY OF ( )  
Signature of Client

Sworn to and subscribed before me on this  
day of \_\_\_\_\_, \_\_\_\_\_.  
Address of Client

My commission expires: \_\_\_\_\_.  
City, State, Zip

\_\_\_\_\_  
Notary's Signature  
SEAL

**MESSAGE THERAPY REGISTRATION PROGRAM**  
**Affidavit of Referral(s)**

**Instructions:** This form is to document massage therapy experience through referrals from other licensed health care professionals. Photocopy if additional copies are needed.

**Section I. (Completed by applicant)**

Name of Applicant: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_  
P.O. Box or Street No. City State Zip

**Section II. (Completed by other licensed health care professional)**

The person certifying to his/her knowledge of the experience of the individual above shall complete the information below:

I, \_\_\_\_\_, as a licensed \_\_\_\_\_, do hereby certify that  
Occupation

I have referred \_\_\_\_\_ patients or clients to \_\_\_\_\_ during the period  
No. Applicant's Name  
of time, from \_\_\_\_\_ to \_\_\_\_\_ and that I know of my own knowledge that said person  
Mo/Day/Yr Mo/Day/Yr  
was engaged in the professional practice of massage therapy as follows:

1. Name and Address of Business \_\_\_\_\_  
\_\_\_\_\_
2. Briefly describe techniques prescribed and/or practiced \_\_\_\_\_  
\_\_\_\_\_
3. Check type of establishment or office in which work was performed:  
G Massage Establishment G Health Spa G Doctor's Office G Other: \_\_\_\_\_
4. Hours of therapy per month \_\_\_\_\_
5. Other pertinent information \_\_\_\_\_

**Section III. (Completed by notary and other licensed health care professional)**

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, in \_\_\_\_\_, \_\_\_\_\_  
City State

I certify under penalty of perjury that the information submitted is true and correct.

STATE OF ( )  
COUNTY OF ( )

\_\_\_\_\_  
Signature of Health Care Professional

Sworn to and subscribed before me on this  
day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Address

My commission expires: \_\_\_\_\_.

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Notary's Signature

SEAL

**MASSAGE THERAPY REGISTRATION PROGRAM  
TEXAS DEPARTMENT OF HEALTH  
1100 WEST 49TH STREET  
AUSTIN, TEXAS 78756-3183**

**PROVISIONAL REGISTRATION  
LICENSE/REGISTRATION VERIFICATION**

Application for registration as a Massage Therapist in the State of Texas, requires this form to be completed by all State Boards in which I hold or have ever held a license. My signature below is your authorization to release all information in your files, favorable or otherwise, regarding myself.

**Section I to be completed by applicant. Please type or print clearly.**

Applicant Name \_\_\_\_\_ License Number \_\_\_\_\_  
Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone Number(include area code) \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Section II. (Completed by out-of-state licensing authority)**

State of \_\_\_\_\_

This certifies that \_\_\_\_\_ is:  
(Applicant's Name)

Registered G    Certified G    Licensed G as a \_\_\_\_\_

License/Registration/Certification Number \_\_\_\_\_

Effective date of License/Registration/Certification \_\_\_\_\_

Current status of this license/registration/certification is:

Active G    Lapsed G    Inactive G    Denied \*\* G    Suspended \*\* G    Revoked \*\* G

**\*\* Please attach a copy of the Findings of Fact and Decision and Order.**

License/Registration/Certification issued based on:

G Education Requirements                      G Endorsement/Reciprocity  
G State Examination                              G Grandfather Requirements  
G National Examination

Qualifications for licensure in this state are:

1. Total hours of education \_\_\_\_\_
2. Number of hours required in Swedish Massage \_\_\_\_\_
3. Number of hours required in Anatomy & Physiology \_\_\_\_\_
4. Written examination required? G Yes G No
5. Practical examination required? G Yes G No

**Please attach a copy of the current massage therapy requirements (rules) for your state. (If current rules have been sent to this office within the last 12 months, please disregard this request.)**

*I certify that the above information is correct and true. I have enclosed a copy of the requirements for this state.*

Name of Agency \_\_\_\_\_ Address \_\_\_\_\_  
Signature \_\_\_\_\_ Typed Name \_\_\_\_\_  
Title \_\_\_\_\_ Date \_\_\_\_\_